MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00358

00361

CERTIFICATE OF DEATH

Reg. Dist. No. 77

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
LENGTH OF STAY (in this place) 20 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED: (Type or Print) (First) ANN (Middle) ELIZABETH (Last) ALBAUGH

4. DATE OF DEATH: (Month) Jan (Day) 16 (Year) 19 55

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: Nov 14 1859

9. AGE last birthday: 95 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Retired

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Basler

14. MOTHER'S MAIDEN NAME: Maria Shorb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) N (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Mrs Oliver Millender - Hampstead Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uremia — Interval Between Onset And Death: 5 mo.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterio-Sclerotic C-V Renal Disease — 15 yrs

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1954, to Jan. 16, 1955, that I last saw the deceased alive on Jan. 15, 1955, and that death occurred at 6:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
M. C. Porterfield M.D. Hampstead, Md Jan 16, 55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Jan 18-1955 — NAME OF CEMETERY OR CREMATORY Leisters cem. — LOCATION (City, town, or county) (State) Carroll Co Md

DATE REC'D BY LOCAL REGISTRAR 1/18/55 — REGISTRAR'S SIGNATURE Henry J Reis

24. FUNERAL DIRECTOR Edw Shipton — ADDRESS Hampstead Md

RECEIVED
JAN 13 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00362

00359

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural - Westminster
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Westminster X
STREET ADDRESS (If rural, give location) X

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Brian	Kenneth	Baker	1-24- 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.
Male	White	Single	9-4-1954		4 / 20	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Maryland	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Paul Richard Baker	Janet Hann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Father - same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

492 X

Immediate cause (a) Pneumonia - Primary atypical — Interval Between Onset and Death: 48 hrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1/23, 1955, to 1/24/55, 19..., that I last saw the deceased alive on 1/23, 1955, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
M. E. Robertson	M.D.	New Windsor, Md.	1/24/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-26-1955	Winters	Carroll Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-25-55	E. M. Farver	E. M. Waltz	Winfield, Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 26 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00363

00360

Reg. Dist. No. 50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor — LENGTH OF STAY (In this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
STREET ADDRESS (If rural give location) Main St.

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) LEWIS (Last) BAKER

4. DATE OF DEATH: (Month) Jan. (Day) 9 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower

8. DATE OF BIRTH: 10/12/1873

9. AGE last birthday: 81 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life (even if retired): farmer retired

10b. KIND OF BUSINESS OR INDUSTRY: owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James E. Baker

14. MOTHER'S MAIDEN NAME: Lizzie Barnhart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no
(If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.: 212-24-5917

17. INFORMANT & ADDRESS: C. O. Baker, New Windsor, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
422.1
Immediate cause (a) Arteriosclerotic Cardio-vascular disease — Interval Between Onset And Death: 5 yrs.
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/1, 1949, to 1/9, 1955, that I last saw the deceased alive on 1/9, 1955, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

SIGNATURE M. E. Robertson (Degree or title) M.D. ADDRESS New Windsor, Md. DATE SIGNED 1/10/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1/12/55 — NAME OF CEMETERY OR CREMATORY Church of God Cem. — LOCATION (City, town, or county) Uniontown — (State) Md.

DATE REC'D BY LOCAL REGISTRAR Jany 11-1954 — REGISTRAR'S SIGNATURE Emma E. Brandt

24. FUNERAL DIRECTOR D. D. Hartzler & Sons — ADDRESS New Windsor, Md.

RECEIVED
JAN 12 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00364

CERTIFICATE OF DEATH

Reg. Dist. No. 00364 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carrol; STATE MARYLAND
   CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural- Sykesville
   LENGTH OF STAY (in this place) 3 y 11 mths
   15 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Balto City
   CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3 V 01-4
   STREET ADDRESS (If rural give location) 1500 W. Baltimore Street

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Thomas (Last) Barron

4. DATE OF DEATH: (Month) 1 (Day) 8 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married.

8. DATE OF BIRTH: 6- 24- 1892

9. AGE last birthday 62 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10B. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Barron

14. MOTHER'S MAIDEN NAME: Hannah Hayes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 4 no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT & ADDRESS: Mary Barron Mays, 1500 W. Baltimore Str.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

522X

IMMEDIATE CAUSE (A) Bilateral pneumonia hypostatic — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with cerebral arteriosclerosis — years

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-20, 1954, to 1-8-, 1955, that I last saw the deceased alive on January 8, 1955, and that death occurred at 2:17 PM, from the causes and on the date stated above.

SIGNATURE Edmund Luethans M.D. ADDRESS Sykesville, Md. DATE SIGNED 1-8- 1955.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL — DATE THEREOF JAN. 12-1955 — NAME OF CEMETERY OR CREMATORY New Cathedral Cem — LOCATION (City, town, or county) (State) 4300 Old Frederick Rd - Balto Md

DATE REC'D BY LOCAL REGISTRAR 1-11-55 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR Thomas J. Kenny Inc. — ADDRESS 1600 Hollins St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00362

00365

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) since 6/2/54
15 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick City 10-11-2
STREET ADDRESS (If rural give location) 118 E. 8th Street

3. NAME OF DECEASED: (Type or Print) (First) Johnathan (Middle) Franklin (Last) BOWERS

4. DATE OF DEATH: (Month) January (Day) 13 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widower

8. DATE OF BIRTH: November 9, 1874

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer

10B. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Frederick, Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 1/ no (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 4200 (A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arteriosclerotic heart disease with hyper- — more than 1 yr.

DUE TO (C) tension

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile psychosis — many years

19A. DATE OF OPERATION: --- 0

19B. MAJOR FINDINGS OF OPERATION ---

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ---

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ---

21E. INJURY OCCURRED While at work ☐ Not while at work ☐ ---

21F. HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Sept. 17, 1954 to Jan. 13, 1955 that I last saw the deceased alive on Jan. 13, 1955, and that death occurred at 11:15 A.M., from the causes and on the date stated above.

SIGNATURE AND M.D. Martin Gross M.D. — ADDRESS Sykesville, Maryland — DATE SIGNED 1/13/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 1/15/55 — NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery — LOCATION (City, town, or county) Frederick (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan. 14, 1955 — REGISTRAR'S SIGNATURE C. Avery Ickes

24. FUNERAL DIRECTOR C. E. Cline & Son — ADDRESS Frederick

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 18 1955
BUREAU V. S.

00366

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00363 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
X CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis 02-10-2
STREET ADDRESS 2 (If rural, give location)

3. NAME OF DECEASED: (First) WILLIAM (Middle) (Last) BOYD
4. DATE OF DEATH: (Month) Jan. (Day) 3, (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Colored	S.	1-2-1917	36 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Lumber yard	Maryland	U.S.A.

13. FATHER'S NAME: William E. Boyd
14. MOTHER'S MAIDEN NAME: Louise [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	212-16-4836	Henry Boyd - [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary tuberculosis
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE R.B. Fisher M. D.
CHIEF MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED Jan. 5, 1955

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	1-11-55	Brewer Hill	Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
1-10-55	A.W. Hedrich dmr.	William Reese, II - 108 Washington St. Annapolis, Md.

rg

00367 MARYLAND STATE DEPARTMENT OF HEALTH 00364

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester — LENGTH OF STAY (in this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Evergreen Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Boring
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Marietta (Middle) (Last) Brown
4. DATE OF DEATH: (Month) January (Day) 29 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Oct 29 1866
9. AGE last birthday: 88 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Randal Baker
14. MOTHER'S MAIDEN NAME: Martha Jane Deall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Mr Charles Brown, Baltimore, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
171X
Immediate cause (a) Generalized Carcinomatosis.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Primary Carcinoma Cervix
(c)

Interval Between Onset and Death: (7) (C)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 27, 1949, to Jan 29, 1955, that I last saw the deceased alive on Jan 27, 1955, and that death occurred at 8 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Frank E Burk M.D. Hampstead Md Jan 29, 1955

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Feb 1 55
NAME OF CEMETERY OR CREMATORY: Druid Ridge
LOCATION (City, town, or county) (State): Balto. County Md.

DATE REC'D BY LOCAL REG.: Jan 30 - 55
REGISTRAR'S SIGNATURE: Mrs. H. P. L. Demmer
24. FUNERAL DIRECTOR: J. Elmer Sons Reclustown Md ADDRESS

RECEIVED
FEB 1 1975
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0365

00368

CERTIFICATE OF DEATH

Reg. Dist. No. 52-83

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Bussard

VS. A15—10-

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mt. Airy
LENGTH OF STAY (in this place) Life
00 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Airy X
STREET ADDRESS (If rural give location) /

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) E. (Last) BUSSARD

4. DATE OF DEATH: (Month) Jan. (Day) 8 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 7-25-1870

9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10B. KIND OF BUSINESS OR INDUSTRY: general

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Rand Bussard

14. MOTHER'S MAIDEN NAME: Mary Cain

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Charles Bussard, Mt. Airy, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
1 IMMEDIATE CAUSE	(A)	Arteriosclerotic Heard Disease	Several years
ANTECEDENT CAUSE (S)	DUE TO	Generalized Arteriosclerosis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO		
	(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. , 1954 to Jan. , 1955, that I last saw the deceased alive on Jan 1 , 1955, and that death occurred at Unknown Time A. M, from the causes and on the date stated above.

SIGNATURE W.B. Culwell M.D. ADDRESS Mt. airy, md DATE SIGNED Jan 8, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

DATE THEREOF: 1-11-1955

NAME OF CEMETERY ~~OR CREMATORY~~: Montgomery Chapel

LOCATION (City, town, or county) (State): Montg. Co. Maryland

DATE REC'D BY LOCAL REGISTRAR: 1-10-1955

REGISTRAR'S SIGNATURE: Dr. Robert R. Hewitt

24. FUNERAL DIRECTOR: C. M. Waltz, Winfield, Md.

ADDRESS

RECEIVED
JAN 1 ..
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00366

00369

CERTIFICATE OF DEATH

Reg. Dist. No. 80

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor
STREET ADDRESS (If rural give location) X 1

3. NAME OF DECEASED: (Type or Print) (First) HOWARD (Middle) GRAYSON (Last) CARBAUGH

4. DATE OF DEATH: (Month) Jan. (Day) 21 (Year) 19 55

5. SEX: male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married | 8. DATE OF BIRTH: 9/28/1885 | 9. AGE last birthday: 69 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): blacksmith retired | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William H. Carbaugh | 14. MOTHER'S MAIDEN NAME: Clara Gurney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no | (If Yes, give war or dates of service) no | 16. SOCIAL SECURITY No.: none | 17. INFORMANT & ADDRESS: Amanda Carbaugh, New Windsor

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

33/X Immediate cause (a) Cerebral hemorrhage — Interval Between Onset And Death: 2 weeks

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c) Chronic bronchitis with asthma years — many

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Myocardial degeneration 3 yrs

19a. DATE OF OPERATION: — | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1947, to Jan 21, 1955, that I last saw the deceased alive on Jan 21, 1955, and that death occurred at 8:15 A.M. from the causes and on the date stated above.
SIGNATURE (Degree or title) Wesley Wilkens (M.D.) ADDRESS Westminster DATE SIGNED 1-21-55

23. BURIAL, CREMATION, REMOVAL (Specify) Buried | DATE 1/23/55 | NAME OF CEMETERY OR CREMATORY Winters Cem. | LOCATION (City, town, or county) Carroll County (State) Md.

DATE REC'D BY LOCAL REGISTRAR Jany 22/55 | REGISTRAR'S SIGNATURE Emerson Benedict

24. FUNERAL DIRECTOR D. D. Feeser & Sons | ADDRESS New Windsor, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00367

00375

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville
LENGTH OF STAY (in this place) 11 yrs 7 days
15 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 31 W. 4
STREET ADDRESS (If rural give location) 128 Lee Street

3. NAME OF DECEASED: (Type or Print) (First) BERNARD (Middle) JAMES (Last) CONNELLY
4. DATE OF DEATH: (Month) 1 (Day) 25 (Year) 19 55
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH. 8/0/74
9. AGE last birthday 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Tinner
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Daniel Connelly
14. MOTHER'S MAIDEN NAME: Ellen Campbell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X IMMEDIATE CAUSE (A) Adenocarcinoma of stomach with metastasis — INTERVAL BETWEEN ONSET AND DEATH: 8 years

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (B)

DUE TO (C) Generalized arteriosclerosis — years

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBC with psychotic reaction — years

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/23, 19 54, to 1/25/, 19 55, that I last saw the deceased alive on 1/25 19 55 and that death occurred at 9:10 A M, from the causes and on the date stated above.
SIGNATURE Arnold Susthaus M.D. ADDRESS Sykesville, Maryland DATE SIGNED 1/25/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 1/27/55
NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.
LOCATION (City, town, or county) (State) Balto., Md.

DATE REC'D BY LOCAL REGISTRAR 1-26-55
REGISTRAR'S SIGNATURE A.W. Hedges
24. FUNERAL DIRECTOR Wm. J. Pickner & Sons
ADDRESS Balto. Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00371 **CERTIFICATE OF DEATH** Reg. Dist. No. 00368 77

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH
06
COUNTY Carroll MARYLAND
X CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: Rural - Sykesville
LENGTH OF STAY (in this place): 3 days
15 HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll 06
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Hampstead X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED (Type or Print): (First) Cora (Middle) A (Last) COOPER

4. DATE OF DEATH: (Month) 1 (Day) 4 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 1885

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John A. Tyrrell

14. MOTHER'S MAIDEN NAME: Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unk (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Congestive heart failure due to		
IMMEDIATE CAUSE	(A) Mitral insufficiency	2 days
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Arteriosclerotic heart disease	years
DUE TO	(C)	
II. SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Psychotic Depression	years

19A. OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/2, 1955, to 1/4, 1955, that I last saw the deceased alive on 1/4, 19 55, and that death occurred at 11:15 AM from the causes and on the date stated above.

SIGNATURE Edmund Lusthaus M. D. ADDRESS Sykesville, Maryland DATE SIGNED 1/4/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Jan 7/55 | NAME OF CEMETERY OR CREMATORY: Hampstead Cemtry | LOCATION (City, town, or county) (State): Carroll Co

DATE REC'D BY LOCAL REGISTRAR: Jan. 5, 1955 | REGISTRAR'S SIGNATURE: C. Harry Baker

24. FUNERAL DIRECTOR: Edw. C. Upton ADDRESS: Hampstead

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00369

00372

CERTIFICATE OF DEATH

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 30 HRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 5

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (if rural, give location) R.D. 5

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
CHARLES	TILDEN	COPENHAVER	1	28	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Widowed	Dec. 28-1874	80 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Ret. Farmer	self employed	Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William Copenhaver	Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	None	Mrs John W. Copenhaver Sr. R.D. 5 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Chronic Myocarditis	
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Chronic Nephritis	24 hrs
DUE TO		
	(c) Angina	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
None		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 1-27, 1955, to 1-28, 1955; that I last saw the deceased alive on 9 A.M. Jan 27, 1955, and that death occurred at 1:10 P m., from the causes and on the date stated above.

SIGNATURE D. C. Jennette M.D. (DEGREE OR TITLE) ADDRESS Westminster DATE SIGNED 1-30-55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan. 31, 1955	Pine Grove Cemetery	Westminster	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-31-55	Hamit Fuller	H. Bankard & Son	Westminster Md.

RECEIVED
FEB 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00373

CERTIFICATE OF DEATH

Reg. Dist. No. 00372

Item 8, FilmC177 2-8-56 at

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural Westminster
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS RD 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster X
STREET ADDRESS (If rural, give location) R.D. 1 X 1

3. NAME OF DECEASED: (Type or Print) (First) JAMES (Middle) W. (Last) CROWDER

4. DATE OF DEATH: (Month) 1 (Day) 27 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 6 - 1893 (1892)

9. AGE last birthday: 61 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): N. Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Marcus Crowder

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Lydia Crowder R.D. 1 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) 151X Cancer of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. metastasis to other organs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 26 1955, to Jan 27, 19....., that I last saw the deceased alive on Jan 26 19 55 and that death occurred at ..... a.m., from the causes and on the date stated above.

SIGNATURE AND DEGREE OR TITLE: C. Reese Nail Jr. M.D. ADDRESS: Westminster DATE SIGNED: 1-29-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 1-29-1955

NAME OF CEMETERY OR CREMATORY: Lon Luther Miller Fun.

LOCATION (City, town, or county): Bachmans Valley (State): Md.

DATE REC'D BY LOCAL REG. 1-29-55

REGISTRAR'S SIGNATURE: Hannit Miller

24. FUNERAL DIRECTOR AND ADDRESS: L.L. Bankard Inc. Westminster, Md.

1955
BUREAU V. S

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00371

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Items 3,9, Film 3177 2-11-55 ec

1. PLACE OF DEATH: MARYLAND
COUNTY Carroll
CITY (If outside corporate limits, write RURAL) OR TOWN Sykesville
LENGTH OF STAY (in this place) 15 yrs. 11 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 607 Bedford St.

3. NAME OF DECEASED: (Type or Print) George (First) (Middle) Dendrinos (Last) (Dendrinos)

4. DATE OF DEATH: (Month) 1 (Day) 27 (Year) 1955

5. SEX: M. | 6. COLOR OR RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) M. | 8. DATE OF BIRTH: 1873 | 9. AGE last birthday 81 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Restaurant Owner

11. BIRTHPLACE (State or foreign country): Greece

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unk.

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Evelyn Dendrinos, 607 Bedford St.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) fracture of L. hip — 25 days
DUE TO (C)

SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. C.B.S. and Ca. with arteriosclerotic brain disease, prostatic resection 1 year

19A. OPERATION: Splint applied 1-16-55 | 19B. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) Springfield State Hosp.

21D. TIME OF INJURY (Month) 1 (Day) 2 (Year) 1955 (Hour) M 9-4 | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-16, 1954 to 1-27, 1955, that I last saw the deceased alive on 1-27, 1955, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

SIGNATURE Dr. Ramm M.D. ADDRESS Sykesville Md. DATE SIGNED 1-27-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1-31-55 | NAME OF CEMETERY OR CREMATORY [illegible] | LOCATION (City, town, or county) (State) (Cumberland, Md.)

DATE REC'D BY LOCAL REGISTRAR Jan. 28, 1955 | REGISTRAR'S SIGNATURE C. [illegible] (by [illegible]) | 24. FUNERAL DIRECTOR (U.S.D. Hinze) ADDRESS (Cumberland, Md.)

MARYLAND STATE DEPARTMENT OF HEALTH

00372

00375

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural--Mt. Airy
LENGTH OF STAY (in this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural--Mt. Airy
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) SARAH (Middle) E. (Last) DRIVER

4. DATE OF DEATH: (Month) Jan. (Day) 4, (Year) 55

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3-26-1876

9. AGE last birthday: 78 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house work

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: Basil Glaze

14. MOTHER'S MAIDEN NAME: Mary E. Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Oliver B. Driver, Mt. Airy, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Embolism	10 da
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio - Vascular disease	3 yrs
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Unhealed burns - both feet — 3 yrs

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1952, to Jan 4, 1955, that I last saw the deceased alive on Jan. 4, 1955, and that death occurred at 9 P.M., from the causes and on the date stated above.

SIGNATURE: J Stanley Grabill (Degree or title) M.D. ADDRESS: Mt. Airy Md DATE SIGNED: 1/6/55

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF: 1-8-1955 — NAME OF CEMETERY OR CREMATORY: Poplar Springs — LOCATION (City, town, or county) (State): Howard Co., Maryland

DATE REC'D BY LOCAL REG.: Jan 8 1955 — REGISTRAR'S SIGNATURE: Forest R. Hewitt

24. FUNERAL DIRECTOR: C. M. Waltz, Winfield, Md. — ADDRESS

RECEIVED
JAN 1? 1?
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00376

CERTIFICATE OF DEATH

Reg. Dist. No. 00373

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH.
COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
MARYLAND
LENGTH OF STAY (in this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3701-4
STREET ADDRESS (If rural give location) 501 East 35th Street

3. NAME OF DECEASED: (Type or Print) (First) [illegible] (Middle) [illegible] (Last) [illegible]

4. DATE OF DEATH (Month) 1 (Day) 18 (Year) 19 55

5. SEX: [illegible]

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 6/18/81

9. AGE last birthday 70 yrs | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cal. grad

10B. KIND OF BUSINESS OR INDUSTRY: [illegible]

11. BIRTHPLACE (State or foreign country): US

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Ferrens

14. MOTHER'S MAIDEN NAME: Elizabeth Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) [illegible] If Yes, give war or dates of service

16. SOCIAL SECURITY NO. [illegible]

17. INFORMANT & ADDRESS. Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.1
IMMEDIATE CAUSE (A) Hypostatic bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C) Laennec's cirrhosis of the liver — Years

SIGNIFICANT CONDITIONS CONTRIBUTING DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction. — Years

19A. OPERATION: [illegible]

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work [ ] Not while at work [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/11, 1955, to 1/18, 1955, that I last saw the deceased alive on 1/18, 1955, and that death occurred at 7:00 AM, from the causes and on the date stated above.

SIGNATURE Edmund Leithoma M. D. ADDRESS Sykesville, Maryland DATE SIGNED 1/18/55

23. BURIAL, CREMATION, REMOVAL, (SPECIFY) [illegible] DATE THEREOF 1-21-55 NAME OF CEMETERY OR CREMATORY [illegible] LOCATION (City, town, or county) (State) [illegible]

DATE REC'D BY LOCAL REGISTRAR 1-19-1955 REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR [illegible] ADDRESS [illegible]

00377 MARYLAND STATE DEPARTMENT OF HEALTH 00374

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 70

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Keymar Rural — LENGTH OF STAY (In this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Detour

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Keymar Rural
STREET ADDRESS (If rural, give location) Detour

3. NAME OF DECEASED (Type or Print): (First) JUNE (Middle) B. (Last) FLEMING

4. DATE OF DEATH: (Month) Jan (Day) 17 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 11/18/1921

9. AGE last birthday: 34 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Warren Bruner

14. MOTHER'S MAIDEN NAME: Blanche Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-18-9060

17. INFORMANT: Husband, Keymar, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
420.1
Immediate cause (a) Coronary Thrombosis
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Found dead in bed
(c)

INTERVAL BETWEEN ONSET AND DEATH: ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE S. Luther Bair, M.D. (Degree or title) ADDRESS Deputy Medical Examiner, Westminster, Md. DATE SIGNED 1/19/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 1/20/55 — NAME OF CEMETERY OR CREMATORY: Mt. Union Cem. — LOCATION (City, town, or county) Union Bridge (State) Md.

DATE REC'D BY LOCAL REG. Jan 20, 1955 — REGISTRAR'S SIGNATURE Ethel M Mehring, local

24. FUNERAL DIRECTOR: D. W. Routzahn & Sons — ADDRESS Union Bridge, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND 00378

00375
STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 2 6

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Carroll — MARYLAND
CITY If outside corporate limits, write RURAL and give nearest town) OR TOWN Reese
LENGTH OF STAY (In this place) 17 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 74 Naples Boarding Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville
STREET ADDRESS (If rural, give location) X / 1

3. NAME OF DECEASED (Type or Print) (First) Laura (Middle) Bell (Last) Gardner

4. DATE OF DEATH (Month) Jan. (Day) 30 (Year) 19 55

5. SEX F.

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH Nov. 2, 1865

9. AGE Last Birthday 89 yrs. If under 1 year Months. If under 24 hrs. Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jacob Gardner

14. MOTHER'S MAIDEN NAME Margaret Toff.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No

(If year, give war or dates of service) —

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Mrs Mae Hollenberg - Hyattsville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial degeneration — Interval between onset and death 5 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)....

(c)....

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. , 1955 to Jan 29 19 55 that I last saw the deceased alive on Jan 29., 1955, and that death occurred at 2:15 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Reed Schildaen M.D. — ADDRESS Westminster — DATE SIGNED 1-31-55

23. BURIAL, CREMATION REMOVAL (Specify) — DATE 2-1-55 — NAME OF CEMETERY OR CREMATORY Providence — LOCATION (City, town, or county) (State) Gamber, Carroll Md.

DATE REC'D BY LOCAL REG. Jan. 31, 1955 — REGISTRAR'S SIGNATURE Hazel K. Grella

24. FUNERAL DIRECTOR Richard E. Height — ADDRESS Hyattsville, Md.

EB 7 1955
REAU V.

00379 MARYLAND STATE DEPARTMENT OF HEALTH 00376

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 77

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead (Rural); LENGTH OF STAY (In this place) 13 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead (Rural); STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) S (Last) GLOVER

4. DATE OF DEATH: (Month) Jan (Day) 7 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug 6 1885

9. AGE last birthday: 69 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: High School

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel W Glover

14. MOTHER'S MAIDEN NAME: Harriet V Deeds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 215-28-5813

17. INFORMANT AND ADDRESS: Mrs Geo Glover - Upperco Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval between onset and death: 2 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE M C Partridge (Degree or title) M.D. ADDRESS Hampstead, Md DATE SIGNED 1-8-55

23. BURIAL, CREMATION REMOVAL (Specify) Burial; DATE THEREOF Jan 10-55; NAME OF CEMETERY OR CREMATORY Deer Park-Methodist; LOCATION (City, town, or county) (State) Carroll Co Md

DATE REC'D BY LOCAL REG. 1/8/55; REGISTRAR'S SIGNATURE M Wells

24. FUNERAL DIRECTOR Edw Clipton, ADDRESS Hampstead Md

VS. A15A

00380

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00377

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and complete answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Mt. Airy
LENGTH OF STAY (in this place): 1½ years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Ridge Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Mt. Airy
STREET ADDRESS (If rural, give location): Ridge Road.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Stanley (Last) Grabill

4. DATE OF DEATH: (Month) January (Day) 30 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 9-24-1897

9. AGE last birthday: 57 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician

10b. KIND OF BUSINESS OR INDUSTRY: Medicine

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John W. Grabill

14. MOTHER'S MAIDEN NAME: Alice M. Stevenson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.: no

17. INFORMANT AND ADDRESS: Mrs. Ruth Neely Grabill, Mt. Airy, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Coronary Thrombosis — Interval Between Onset and Death: Instantaneous

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1953, to Jan., 1955, that I last saw the deceased alive on Jan. 28, 1955, and that death occurred at 7 45 A. m., from the causes and on the date stated above.

SIGNATURE: W. B. Culwell (Degree or title) M.D. ADDRESS: Mt Airy Md. DATE SIGNED: Jan 30, 1955

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: 2-2-1955 — NAME OF CEMETERY ~~OR CREMATORY~~: Pine Grove — LOCATION (City, town, or county) (State): Mt. Airy, Md.

DATE REC'D BY LOCAL REG.: Feb 1st 1955 — REGISTRAR'S SIGNATURE: Robert B. Hewitt

24. FUNERAL DIRECTOR: C. M. Waltz, ADDRESS: Winfield, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00381

CERTIFICATE OF DEATH

Reg. Dist. No. 00378

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 19 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
STREET ADDRESS (If rural give location) P.O. Box 217.

3. NAME OF DECEASED: (Type or Print) First: Ruth Middle: Virginia Last: Haines

4. DATE OF DEATH: (Month) 1 (Day) 29 (Year) 1955

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 7-2-1880

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): not known

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard W. MacCubbin

14. MOTHER'S MAIDEN NAME: Mary Virginia Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Hospital Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

42 a.1 IMMEDIATE CAUSE (A) DUE TO: Cerebral embolism — minutes

ANTECEDENT CAUSE (B) DUE TO: Arterio-sclerotic cardio. vascular disease — years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II. SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: C.B.S. with convulsive disorder & psychosis — years

19A. OPERATION: U

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-10-1955 to 1-29, 1955 that I last saw the deceased alive on 1-28, 1955, and that death occurred at 7 45 AM, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnendeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 1/29/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR January 31, 1955

REGISTRAR'S SIGNATURE C. Harry Heer

24. FUNERAL DIRECTOR ADDRESS

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00382

CERTIFICATE OF DEATH

Reg. Dist. No. 00379 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) since 10/3/53
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
STREET ADDRESS (If rural give location) Route #6

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Covington (Last) HAMMOND

4. DATE OF DEATH: (Month) Jan. (Day) 13 (Year) 1955

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: February 17, 1883
9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Westminster, Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Philip Hammond
14. MOTHER'S MAIDEN NAME: Ruth Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ---
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

332 ×

IMMEDIATE CAUSE (A) Cerebral thrombosis — 3 weeks

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized arteriosclerosis — more than 2 yrs

DUE TO

(C)

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with cerebral arteriosclerosis — more than 2 yrs

19A. DATE OF OPERATION: ---
19B. MAJOR FINDINGS OF OPERATION ---
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ---
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. ---
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Sept. 14 1954 to Jan. 13, 1955 that I last saw the deceased alive on Jan. 13, 1955, and that death occurred at 11:35 P.M., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. ADDRESS M. D. Sykesville, Maryland DATE SIGNED Jan. 13, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 1-17-55
NAME OF CEMETERY OR CREMATORY: [illegible]
LOCATION (City, town, or county) (State): [illegible]

DATE REC'D BY LOCAL REGISTRAR: Jan. 13, 1955
REGISTRAR'S SIGNATURE: [illegible]
24. FUNERAL DIRECTOR: [illegible] ADDRESS: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00380

00383 CERTIFICATE OF DEATH Reg. Dist. No. 7D

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND Md
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown Rural
LENGTH OF STAY (in this place) 58 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: 06X-1
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Taneytown-Rural
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Boyd (Last) Hockensmith

4. DATE OF DEATH: (Month) Jan (Day) 1 (Year) 1955.

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married | 8. DATE OF BIRTH: Sept.18,1896 | 9. AGE last birthday: 58 yrs. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farm labor
10B. KIND OF BUSINESS OR INDUSTRY: [redacted]
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles R. Hockensmith
14. MOTHER'S MAIDEN NAME: Minnie Boyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) Yes | (If Yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Hilda Shaffer Hockensmith-Taneytown,Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1
IMMEDIATE CAUSE
(A) Chronic Myocarditis and Myocardial Degeneration (Non Rheumatic) — 1 yr.
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B)
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized Arteriosclerosis — 2 yrs.

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 4, 1954, to 1/1 ..., 1955, that I last saw the deceased alive on Dec. 30, 1954, and that death occurred at 3 A. M, from the causes and on the date stated above.
SIGNATURE R. S. McVaugh M.D. ADDRESS Taneytown, Md. DATE SIGNED 1/4/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | DATE THEREOF Jan, 5, 1955 | NAME OF CEMETERY OR CREMATORY Lutheran | LOCATION (City, town, or county) (State) Taneytown, Md.

DATE REC'D BY LOCAL REGISTRAR Jan 4, 1955 | REGISTRAR'S SIGNATURE Ethel M Mehring Local
24. FUNERAL DIRECTOR C.O.FUSS & SON ADDRESS Taneytown, Md.

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00384

CERTIFICATE OF DEATH

00381

Reg. Dist. No. 8/

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Union Bridge
LENGTH OF STAY (in this place) 3 Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Alexander Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Walkersville 10 X-2
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) Rosa (Middle) Harriett (Last) Jacobs

4. DATE OF DEATH: (Month) January (Day) 22, (Year) 1955

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widow | 8. DATE OF BIRTH: March 4, 1887 | 9. AGE last birthday 67 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | 10B. KIND OF BUSINESS OR INDUSTRY: Home | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Josiah A. Wimpigler | 14. MOTHER'S MAIDEN NAME: Mary Ellen Joy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No. | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S ADDRESS: Calvin Jacobs - Walkersville Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

200.1

IMMEDIATE CAUSE (A) Sarcoma of the Lymphatics 6 mos

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0 | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc. | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 6, 1954 to 1-22, 1955 that I last saw the deceased alive on 1-21-, 1955, and that death occurred at 12:20 M, from the causes and on the date stated above.

SIGNATURE J. H. Seggerman M.D. | ADDRESS Union Bridge, Md. | DATE SIGNED 1/22/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1/25/1955 | NAME OF CEMETERY OR CREMATORY Mount Hope Cem. | LOCATION (City, town, or county) Woodsboro, Md (State)

DATE REC'D BY LOCAL REGISTRAR 25 Jan 1955 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR M. R. Etchison and Son, Frederick, Md ADDRESS

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00385

Reg. Dist. No. 00382

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — STATE MARYLAND
X CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Henryton — LENGTH OF STAY (in this place) 2mths 28days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 23 HENRYTON STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Pr.Geo.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights
STREET ADDRESS (If rural give location) 606 Sixtieth Place

3. NAME OF DECEASED: (Type or Print) (First) LOUISE (Middle) ESLANDA (Last) JEFFERSON

4. DATE OF DEATH: (Month) Jan., (Day) 6 (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3-22-1881

9. AGE Last birthday: 73 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Christopher McKinney

14. MOTHER'S MAIDEN NAME: Lina Miller

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: Unknown

17. INFORMANT & ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Minimal pul. tbc. right

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — DUE TO (b) ; DUE TO (c)

Interval Between Onset And Death: approximately 4,1954

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 8, 19 54, to Jan. 6, 19 55, that I last saw the deceased alive on Jan. 6, 19 55, and that death occurred at 2:45 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) T.F. Vestal M.D. — ADDRESS Henryton, Md. — DATE SIGNED 1-6-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1-11-55 — NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem. — LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REGISTRAR 1-6-55 — REGISTRAR'S SIGNATURE Albert A. Swanborn, Deputy Local — 24. FUNERAL DIRECTOR Robt. G. McGuire — ADDRESS 1820-9th St NW Washington D.C.

RECEIVED
JAN 13 1955
BUREAU V. S.

00336

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00383

CERTIFICATE OF DEATH

Reg. Dist. No. 12

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural Westminster — LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 94 Reese, Md. Caple Boarding Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 27 Colonial Avenue

3. NAME OF DECEASED (Type or Print): (First) Susan (Middle) Rebecca (Last) Jones
4. DATE OF DEATH: (Month) Jan. (Day) 16 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec. 24, 1862
9. AGE last birthday: 92 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Carroll County Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Frock
14. MOTHER'S MAIDEN NAME: Eliza Bankert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. - - - - - -
17. INFORMANT AND ADDRESS: Chas. P. Jones Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

11-20-1 Immediate cause (a) Coronary Thrombosis — Interval between onset and death: Several hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Arterio sclerosis Coronary Sclerosis — 8-10 yrs
(c) Myocardial degeneration — several yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1950, to Jan. 16, 1955, that I last saw the deceased ~~alive~~ dead on Jan. 16, 1955, and that death occurred at 9:15 A m., from the causes and on the date stated above.

SIGNATURE: Glenn Speicher (Degree or title) ADDRESS MD Westminster Md. DATE SIGNED 1/16/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Jan. 19, 1955
NAME OF CEMETERY OR CREMATORY: Krider's Cemetery
LOCATION (City, town, or county) (State): nr Westminster, Md.

DATE REC'D BY LOCAL REG.: Jan. 8, 1955
REGISTRAR'S SIGNATURE: Hanie Miller
24. FUNERAL DIRECTOR: John R. Byers — ADDRESS: Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00384

00387 CERTIFICATE OF DEATH. Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 12 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, Maryland 3V-1-4
STREET ADDRESS (If rural give location) (Not known)

3. NAME OF DECEASED: (Type or Print) (First) Kathleen (Middle) W. (Last) Knight
4. DATE OF DEATH (Month) Jan. (Day) 18 (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed
8. DATE OF BIRTH: November 11, 1872
9. AGE last birthday: 82 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sewer
10B. KIND OF BUSINESS OR INDUSTRY: Sewing Factory
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Chiffney Puckett
14. MOTHER'S MAIDEN NAME: Adelaid Brady

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Pneumonia	few days
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Chronic Brain Syndrome c senile brain desease c psychotic reaction	many years
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Generalized Arteriosclerosis	many years

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-15, 1954, to 1-18, 1955, that I last saw the deceased alive on 1-17, 1955, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

SIGNATURE ADDRESS DATE SIGNED
Garland Sonnenfeldt M.D. Springfield State Hospital Sykesville Md. 1-18-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 1/20/55
NAME OF CEMETERY OR CREMATORY: Linwin Park
LOCATION (City, town, or county) (State): Baltimore Md

DATE REC'D BY LOCAL REGISTRAR: 1-19-55
REGISTRAR'S SIGNATURE: A W Hedrick
24. FUNERAL DIRECTOR: Joseph T Linthicum ADDRESS: 1328 Eutaw Pl Baltimore Md

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00385

00355

CERTIFICATE OF DEATH

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster — LENGTH OF STAY (in this place) 42 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 75 Penna. Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 75 Penna. Avenue

3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH: (Month) (Day) (Year)	5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
HARRY LEVINE LIPPY	JAN. 21 1955	M	W	Widowed	March 9 1878	76 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas L Lippy
14. MOTHER'S MAIDEN NAME: Jane Harris
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Louise Lippy Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	7 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Generalized Arteriosclerosis.	years
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS:
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from ....., 19 52, to 1/21, 19 55, that I last saw the deceased alive on 1/20, 19 55, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE James L Thomas (DEGREE OR TITLE) M. D. ADDRESS Westminster Md DATE SIGNED 1/22/55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan. 24, 1955	Lisitors Cemetery	Westminster	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 25 1955	Hazel Miller	H Bankard Son	Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00386

00388

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH: COUNTY: Carroll; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Sykesville; MARYLAND; LENGTH OF STAY (in this place): 7 mos. 7 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: ; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore; STREET ADDRESS (If rural give location): 311 University Place, Balto. 3 Vol-4

3. NAME OF DECEASED (Type or Print): (First) DANIEL (Middle) FRANCIS (Last) LOUGHLIN

4. DATE OF DEATH: (Month) 1 (Day) 21 (Year) 19 55

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: 11/11/62

9. AGE last birthday: 92 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager

10B. KIND OF BUSINESS OR INDUSTRY: Grocery chain store

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lawrence Loughlin

14. MOTHER'S MAIDEN NAME: Elizabeth — ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X

IMMEDIATE CAUSE (A): Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSE (B) DUE TO:

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO:

(C)

II SIGNIFICANT CONDITIONS CONTRIBUTING DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH: Chronic Brain Syndrome associated with senile brain disease, with psychotic reaction year

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/7/55, 19 , to 1/21 , 19 55, that I last saw the deceased alive on 1/21, 19 55, and that death occurred at 12 Noon, from the causes and on the date stated above.

SIGNATURE AND M. D.: W. H. Tommasulo — ADDRESS: Sykesville, Maryland — DATE SIGNED: 1/21/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: 1-24-55 — NAME OF CEMETERY OR CREMATORY: Bay [illegible] — LOCATION (City, town, or county) (State): Lawrence, N. Y.

DATE REC'D BY LOCAL REGISTRAR: Jan. 21, 1955 — REGISTRAR'S SIGNATURE: C. Harry Zieb

24. FUNERAL DIRECTOR: [illegible] Cook, Inc. — ADDRESS: 1212 Light St. Balto. 30

00357 X-6

00387
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 26

I. PLACE OF DEATH:

COUNTY Carroll MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster

LENGTH OF STAY (In this place) 27 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS 12 Haven Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Carroll

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Westminster 27

STREET ADDRESS (If rural, give location) 12 Haven Avenue 1

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
THOMAS	RAYMOND	MacDONALD	June	12	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Married	Jan. 16, 1896	58 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Electrician	Public	Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Thom. MacDonald	Nellie Bott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
yes World War I	217-20-8164	Mrs Katherine MacDonald Westminster, Md. 12 Haven Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	1 hour
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒
0		

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Harned M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 1-12-55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-14-1955	Pleasant View Cem.	Hampstead, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-13-55	Harold Nusbaum	Ed. Simkins & Son	Westminster, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

00388

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00388

CERTIFICATE OF DEATH

Reg. Dist. No. 74

Item 12, Pilmg176 2-2-55 et

1. PLACE OF DEATH.
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 3 yr. 2 mo. 25 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3 W 2 - 4
STREET ADDRESS (If rural give location) 22 S. Washington Street

3. NAME OF DECEASED: (Type or Print) (First) SOPHIE (Middle) (Last) MALINOWSKI

4. DATE OF DEATH (Month) (Day) (Year) January 26 1955

5. SEX Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married | 8. DATE OF BIRTH: 1884 | 9. AGE last birthday 70 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? Poland

13. FATHER'S NAME: Wallace Pychner

14. MOTHER'S MAIDEN NAME: Anne Faust

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Aspiration pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Pulmonary hemorrhage — 3 days

DUE TO (C) Pulmonary tuberculosis - far-advanced — Years

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Schizophrenia, paranoid, long-standing pulmonary tuberculosis. — Years

19A. OPERATION: —

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-31, 1951, to 1-26, 1955, that I last saw the deceased alive on 1-25-, 1955, and that death occurred at 1:50 A M, from the causes and on the date stated above.

SIGNATURE Roy W. Hayes M.D. ADDRESS Springfield State Hospital DATE SIGNED 1-26-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Jan 29 55 | NAME OF CEMETERY OR CREMATORY Holy Rosary Cem | LOCATION (City, town, or county) (State) Balto. County

DATE REC'D BY LOCAL REGISTRAR 1-27-55 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR John M. Welby | ADDRESS 401 N. Chester St

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00389

00357

CERTIFICATE OF DEATH

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster

LENGTH OF STAY (in this place) 7 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS 119 W. Main

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Carroll

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster

STREET ADDRESS (If rural, give location) 119 W Main

3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH: (Month) (Day) (Year)	5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
Augustus Howard Manger	1 — 12 1955	M	W	Married	Sept. 2, 1883	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Plasterer		Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
George Manger	Amanda Stansbury

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
331 X		
Immediate cause	(a) Cerebral Hemorrhage	8 da
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Arteriosclerosis (General) x	10 yrs
DUE TO	Hypertension	
	(c) Cerebral Hemorrhage	1948

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Jan. 5, 19 55, to Jan. 12, 19 55, that I last saw the deceased alive on Jan. 12, 19 55, and that death occurred at 10:30 P. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

W. Glenn Reichel Westminster Md Jan 13-1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1-16-1955	Kruders Cemetery	Westminster	Md.

DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1-13-55	Harold Miller	H Bankard Hon	Westminster, Md.

RECEIVED
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00390

00390

CERTIFICATE OF DEATH

Reg. Dist. No. 50

Item 7, Film 1175 1-11-55 et

1. PLACE OF DEATH: Meadow View Nursing Home
06 COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town). OR TOWN Near Westminster RD | LENGTH OF STAY (in this place) 1-yr
X
HOSPITAL OR INSTITUTION OR STREET ADDRESS
00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Keymar X
STREET ADDRESS (If rural, give location) Md 1

3. NAME OF DECEASED: (Type or Print) (First) Bessie (Middle) Virginia (Last) Mehring
4. DATE OF DEATH: (Month) 1 (Day) 2 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Widowed	Aug 30 1878	76 yrs.	4	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carroll Co Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Geo W. Dern
14. MOTHER'S MAIDEN NAME: Amanda Ellen Poulson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Clarence Dern, Taneytown Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Myocardial failure	3 days
	DUE TO	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Arteriosclerotic C.V. Disease	years
	DUE TO	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 29, 1954, to June 21, 1955, that I last saw the deceased alive on Dec 31, 1954, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
James J. Mansell M.D. Westminster Md 1-3-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 1-5-55
NAME OF CEMETERY OR CREMATORY Haugh's
LOCATION (City, town, or county) (State) Keymar Frederick Co. Md
DATE REC'D BY LOCAL REG. 1-3-55
REGISTRAR'S SIGNATURE Hamit Martin
24. FUNERAL DIRECTOR Raymond K. Wright ADDRESS Union Bridge Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

JAN 6
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00391

CERTIFICATE OF DEATH

00391

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Manchester
LENGTH OF STAY (in this place) MARYLAND 17yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS Long View Nurs Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) BERTHA (Middle) V (Last) MICHAEL

4. DATE OF DEATH: (Month) Jan (Day) 17 (Year) 19 55

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH: July 10-1892

9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John E Michael

14. MOTHER'S MAIDEN NAME: Clara E Ziegler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: 195-26-1873

17. INFORMANT & ADDRESS: Mrs Harry Mansmore Westminster Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypernephroma (Rt. Kidney

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Metastasis (Spinal)

DUE TO (c)

Interval Between Onset And Death: 4 yrs. 3 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1946

19b. MAJOR FINDINGS OF OPERATION Hypernephroma.

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1946, to Jan. 17, 1955, that I last saw the deceased alive on Jan. 16, 1955, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE M. C. Butterfield (Degree or title) M.D. ADDRESS Hampstead Md DATE SIGNED 1-18-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Jan 20/55 NAME OF CEMETERY OR CREMATORY St Peters LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan 18-55 REGISTRAR'S SIGNATURE Mrs. W. P. L. Benner

24. FUNERAL DIRECTOR Edw C Tipton ADDRESS Hampstead Md

00392

MARYLAND 00392

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 26 71

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Near Mayberry (Uniontown District) — LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westminster, Md. R.D.7

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Near Mayberry
STREET ADDRESS (If rural, give location) Westminster, Md. R.D.7

3. NAME OF DECEASED (Type or Print): (First) Horace (Middle) — (Last) Myers
4. DATE OF DEATH: (Month) 1/8/55 (Day) (Year) 19

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: 8/13/1884
9. AGE last birthday: 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Painter
10b. KIND OF BUSINESS OR INDUSTRY: Painting, All kinds.
11. BIRTHPLACE (State or foreign country): Carroll County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Rufus Myers
14. MOTHER'S MAIDEN NAME: Mary Gouker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mrs. Sterling Hickinger R.D.7 Westminster, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — 1/2 hr.
Antecedent cause(s) (b) arteriosclerosis
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1952 to Jan 8, 1955, that I last saw the deceased alive on Dec 28, 1954, and that death occurred at 9 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. Lee Hilkens C.M.D. Westminster 1/10/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 1/11/55
NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery
LOCATION (City, town, or county) (State): Silver Run, Carroll Co. Md.

DATE REC'D BY LOCAL REG. 1-10-55
REGISTRAR'S SIGNATURE: Howard Shelton Deputy Registrar
24. FUNERAL DIRECTOR: J.W. Little & Son ADDRESS: Littlestown, Pa.
Per P. A. Little, Partner

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00393

00393

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH.
COUNTY Carroll
X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
MARYLAND LENGTH OF STAY (in this place) 8 mos.
15 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 1112 Guilford Avenue

3. NAME OF DECEASED: (Type or Print) (First) MATTIE (Middle) LOU (Last) O'DWYER

4. DATE OF DEATH: (Month) 1 (Day) 10 (Year) 1955

5. SEX Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed | 8. DATE OF BIRTH. March 7, 1864 | 9. AGE last birthday (IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.) 90 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: None | 11. BIRTHPLACE (State or foreign country). Virginia | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Willis Enroughty | 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO Unk- | 17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE 4 4 [illegible]	(A) Myocardial degeneration	years
ANTECEDENT CAUSE (B)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Impressive cardio-vascular disease	years
	DUE TO	
	(C)	
SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH.	CBS assoc. with disturbance of growth, metabolism, or nutrition, with senile brain dis., with psychotic reaction.	Approx. 1 year

19A. [illegible] OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 20, 1954 to 1-10, 1955 that I last saw the deceased alive on 1-10, 1955 and that death occurred at 2 05 P.M., from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt. M.D. ADDRESS Springfield State Hospital DATE SIGNED 1-10-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-14-55	Oakwood	Fairmont, W. Va.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 12, 1955	C. Fahey [illegible]	C.M. SUDER & SON	HAGERSTOWN MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00394

00394

CERTIFICATE OF DEATH

Reg. Dist. No. 7f

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Sykesville — LENGTH OF STAY (in this place) 11y 7mo — HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland COUNTY — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V-21-4 — STREET ADDRESS (If rural give location) not known

3. NAME OF DECEASED (Type or Print): (First) John (Middle) W. (Last) Rockard

4. DATE OF DEATH: (Month) 1 (Day) 29 (Year) 1955

5. SEX: male — 6. COLOR OR RACE: white — 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed — 8. DATE OF BIRTH: 3-7-1884 — 9. AGE last birthday: 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet metal worker — 10B. KIND OF BUSINESS OR INDUSTRY.

11. BIRTHPLACE (State or foreign country): Maryland. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Rockard — 14. MOTHER'S MAIDEN NAME: Molly Chalk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): not known — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. ~~not known~~ 214-14-1233

17. INFORMANT & ADDRESS. Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) DUE TO: Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSE (B) DUE TO: arteriosclerotic cardio-vascular disease years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO: Pulmonary Tuberculosis for advanced years

II. SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Involutional psychosis. — 11y+

19A. OPERATION: 0 — 19B. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July-1-1950 to Jan.-29 1955 that I last saw the deceased alive on 1-29, 1955, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

SIGNATURE AND M.D. Walter H. Rauenfeldt — ADDRESS Springfield State Hospital — DATE SIGNED 1/29/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: Feb 1-1955 — NAME OF CEMETERY OR CREMATORY: Meadowridge — LOCATION (City, town or county): Md (State)

DATE REC'D BY LOCAL REGISTRAR: 1-31-55 — REGISTRAR'S SIGNATURE: A W Hahn — 24. FUNERAL DIRECTOR: H.H. & H.M. Walters — ADDRESS: Lucky 375

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00395/54

00395 CERTIFICATE OF DEATH Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1 PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
LENGTH OF STAY (in this place) since 2/16/54
15 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster X
STREET ADDRESS (If rural give location) Route #4

3 NAME OF DECEASED: (Type or Print) (First) Andrew (Middle) Upton (Last) RHOTEN

4. DATE OF DEATH: (Month) January (Day) 13 (Year) 1955

5. SEX male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married | 8. DATE OF BIRTH. August 1876 | 9. AGE last birthday: 78 yrs. | IF UNDER 1 YEAR: Months — Days — | IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Self employed
10B. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13 FATHER'S NAME: unknown Geo Rhoten
14. MOTHER'S MAIDEN NAME: unknown Corey Miller

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.) no | (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO unknown None
17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

441 X
IMMEDIATE CAUSE (A) Malignant hypertensive cardiovascular — INTERVAL BETWEEN ONSET AND DEATH: more than 8 yrs.
ANTECEDENT CAUSE (B) DUE TO disease
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) —
DUE TO —
(C)

SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Psychosis with hypertension — 1½ yrs.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B PLACE (Home, farm, factory OF INJURY street, office bldg., etc.) —
21C WHERE DID INJURY OCCUR? (City or town) (County) (State) —
21D TIME OF INJURY (Month) (Day) (Year) (Hour) M. —
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Mar. 20, 1954 to Jan. 12, 1955 that I last saw the deceased alive on Jan. 12, 1955, and that death occurred at 6:05 AM, from the causes and on the date stated above.

SIGNATURE Martin Gross M. D. ADDRESS Martin Gross, M.D. Sykesville, Md. DATE SIGNED 1/13/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Jan 15 55 | NAME OF CEMETERY OR CREMATORY Shiloh Cemtry | LOCATION (City, town, or county) Carroll Co. | (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan. 14, 1955 | REGISTRAR'S SIGNATURE C. Geary Hurd | 24. FUNERAL DIRECTOR Edw. C. Tipton | ADDRESS Hampstead Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00396

00396 **CERTIFICATE OF DEATH** Reg. Dist. No. 7X

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 4 mos 11 days
15 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Md. 3Y 14
STREET ADDRESS (If rural give location) 1504 Lakeside Ave

3. NAME OF DECEASED (Type or Print): (First) Rose (Middle) Linda (Last) Roberts
4. DATE OF DEATH: (Month) 1 (Day) 21 (Year) 1955

5 SEX female | 6 COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow | 8. DATE OF BIRTH. not known | 9. AGE last birthday 71 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife | 10B KIND OF BUSINESS OR INDUSTRY: 2/22 | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard L. Brown
14. MOTHER'S MAIDEN NAME: Wilhelmina ?

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) | 16 SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hospital Records.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

541.1 IMMEDIATE CAUSE (A) Terminal pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSE (S) DUE TO (B) perforated duodenal ulcer — hours

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) one mile hot perforated duodenal ulcer — years

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Chronic bronchitis & emphysema due to senile changes & ht psychosis — years

19A DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES X NO

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-19, 1954 to 1-21, 1955, that I last saw the deceased alive on 1-21, 1955, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

SIGNATURE Walter H. Sonnenfeld. M.D. ADDRESS Springfield State Hospital DATE SIGNED 1/22/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Jan. 25. 1955 | NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | LOCATION (City, town, or county) Baltimore Md. (State)

DATE REC'D BY LOCAL REGISTRAR 1-24-55 | REGISTRAR'S SIGNATURE H.W. Hedrick | 24. FUNERAL DIRECTOR Henry Sander & Sons Inc. ADDRESS Baltimore Md. Henry Sander

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00397

00355

CERTIFICATE OF DEATH

Reg. Dist. No. 7-6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 81 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 80 Liberty St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) 80 Liberty St.

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) DAVID (Last) ROYER

4. DATE OF DEATH: (Month) Jan (Day) 24 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: Oct. 13, 1873

9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): engineer

10b. KIND OF BUSINESS OR INDUSTRY: ice plant

11. BIRTHPLACE (State or foreign country): Carroll Co; Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christian Royer

14. MOTHER'S MAIDEN NAME: Lucilla Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.: 213-05-3302

17. INFORMANT & ADDRESS: Ennis Royer, Westminster Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: 5 min.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Cardio-Vascular disease — 5 years

DUE TO

(c)

420.1

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) no

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) no m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 15, 1947, to Jan. 24, 1955, that I last saw the deceased alive on Jan. 22, 1955, and that death occurred at 6:15 P.M. from the causes and on the date stated above.

SIGNATURE C. F. Beitzel (Degree or title) M.D. ADDRESS Westminster, Md. DATE SIGNED 1-24-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Jan. 26/55 — NAME OF CEMETERY OR CREMATORY Meadow Branch — LOCATION (City, town, or county) Rural, Westminster Md. (State)

DATE REC'D BY LOCAL REGISTRAR Jan. 26 1955 — REGISTRAR'S SIGNATURE Harriet Miller

24. FUNERAL DIRECTOR J. S. Myers Jr. — ADDRESS Westminster, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00398

00397 CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
06 COUNTY Carroll
X CITY (If outside corporate limits, write RURAL) OR TOWN Finksburg
LENGTH OF STAY (in this place) MARYLAND 2 mo.
CO HOSPITAL OR INSTITUTION OR STREET ADDRESS Finksburg, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll 6
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethel Heights, Finksburg
STREET ADDRESS (If rural give location) Bethel Road

3. NAME OF DECEASED: (Type or Print) (First) EFFIE (Middle) ESTELLE (Last) RUSSELL

4. DATE OF DEATH: (Month) Jan. (Day) 4 (Year) 1955

5. SEX: F.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: Jan 24, 1882

9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) home-keeper

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Westfieldsburg, Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Beggs

14. MOTHER'S MAIDEN NAME: Martha Stoner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) —

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Edw C. Russell, Finksburg Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral [illegible] age — Interval Between Onset And Death: 1 week

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Hypertensive Cardiovascular disease — 12 yrs +

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from [illegible], 19[illegible], to Jan 4, 1955, that I last saw the deceased alive on Dec. 25, 1954, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm. Reese Neil ADDRESS Westminster DATE SIGNED 1-6-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Jan. 7. 55

NAME OF CEMETERY OR CREMATORY Meadow Branch

LOCATION (City, town, or county) (State) Rural, Westminster, Md.

DATE REC'D BY LOCAL REGISTRAR 1-6-55

REGISTRAR'S SIGNATURE Harold H. Mills

24. FUNERAL DIRECTOR J. E. Myers Jr. ADDRESS Westminster, Md.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00398 54

00398 CERTIFICATE OF DEATH

Reg. Dist. No. 14

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
06 COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
MARYLAND LENGTH OF STAY (in this place) 20yrs
15 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 1107 Sargent St.

3. NAME OF DECEASED: (Type or Print) (First) Alfred (Middle) H. (Last) Seligman

4. DATE OF DEATH: (Month) Jan. (Day) 6 (Year) 1955

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: 1-3-75

9. AGE last birthday IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 80 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist

10B. KIND OF BUSINESS OR INDUSTRY: supply comp.

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Seligman

14. MOTHER'S MAIDEN NAME: Wilhelmina Reinert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no 4 (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 222

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

49 *

IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 12 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

R SIGNIFICANT CONDITIONS CONTRIBUTING DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. General paresis — 20 yrs.

19A. OF OPERATION: U

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Spt. 1, 1947, to Jan. 6, 1955, that I last saw the deceased alive on Jan. 5, 1955, and that death occurred at 4:35A M. from the causes and on the date stated above.

SIGNATURE AND ADDRESS: Martin Gross, M.D. Sykesville, Md.

DATE SIGNED: Jan. 6, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 1/8/54

NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.

LOCATION (City, town, or county) (State): 3801 Frederick Ave.

DATE REC'D BY LOCAL REGISTRAR: 1-6-55

REGISTRAR'S SIGNATURE: V. in Hedrick

24. FUNERAL DIRECTOR: John J. Govan & Son

ADDRESS: 1 E. Pratt St.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00400

00399

CERTIFICATE OF DEATH

Reg. Dist. No. 78

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Taneytown Rural
LENGTH OF STAY (in this place) 66 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown Rural X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) A (Last) Shoemaker

4. DATE OF DEATH: (Month) Jan (Day) 27 (Year) 19 55.

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Dec. 31, 1888

9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10B. KIND OF BUSINESS OR INDUSTRY: own farm

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Shoemaker

14. MOTHER'S MAIDEN NAME: Mary Stuller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No 4 (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Mrs. Marlin Fair Taneytown, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Acute Coronary Artery Occlusion — Few Min.

ANTECEDENT CAUSE (B) DUE TO Coronary Arteriosclerosis — 5 yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Myocarditis & Myocardial Degeneration — 10 yrs. Generalized Arteriosclerosis — 10 yrs.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/15, 1942 to 1/27, 1955 that I last saw the deceased alive on 1/23, 1955, and that death occurred at 4:30 A.M, from the causes and on the date stated above.

SIGNATURE R. D. McVaugh M. D. ADDRESS Taneytown, Md. DATE SIGNED 1/28/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): burial

DATE THEREOF: Jan. 29-55

NAME OF CEMETERY OR CREMATORY: Reformed Church

LOCATION (City, town, or county) (State): Taneytown, Md.

DATE REC'D BY LOCAL REGISTRAR: Jan 28, 1955

REGISTRAR'S SIGNATURE: Ethel M Mehring

24. FUNERAL DIRECTOR: C.O. FUSS & SON

ADDRESS: Taneytown, Md.

RECEIVED
3 1 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Board

CERTIFICATE OF DEATH

Reg. Dist. No. 00401

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville
LENGTH OF STAY (in this place) 34y 1mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
STREET ADDRESS (If rural give location) 21 E 2

3. NAME OF DECEASED: (Type or Print) (First) Maud (Middle) M. (Last) Snyder

4. DATE OF DEATH: (Month) 1 (Day) 21 (Year) 1955

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: March-24-1887

9. AGE last birthday: 67 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel J. Snyder

14. MOTHER'S MAIDEN NAME: Mary Dusang

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260 x

IMMEDIATE CAUSE (A) Arteriosclerotic - Cardio - Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSE (B) DUE TO Diabetes — years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Gangrenous ulcers (multiple) — 3 mo +.

SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Dementia praecox catatonic type — 39 y +

19A. DATE OF OPERATION: A

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-30-1954 to 1-21, 1955, that I last saw the deceased alive on 1-21-, 1955, and that death occurred at 6:20 P M, from the causes and on the date stated above.

SIGNATURE Walther H Sommenfeldt M.D. ADDRESS Springfield State Hosp. DATE SIGNED 1/22/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 1/24/55

NAME OF CEMETERY OR CREMATORY Rose Hill

LOCATION (City, town, or county) Hagerstown (State) Md

DATE REC'D BY LOCAL REGISTRAR Jan 22, 1955

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Fred W Kreiss ADDRESS Hagerstown Md

00401

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00402 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY CARROLL MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Rural - Sykesville

LENGTH OF STAY (in this place) 1Y 1M 24 D

HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore

STREET ADDRESS (If rural, give location) 506 West Mulberry Street

3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
(Type or Print) MALVERN HILL SPANGLER	1/ 27/ 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	W	Divorced	2/9/1872	82 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Refinisher	Work	Virginia	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Clifton Spangler	Mary Perry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	Unk.	Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
9c 2.7 Immediate cause	(a) Cerebral Embolism	minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Fracture, left femur	19 days
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated with senile brain disease, with psychotic reaction — 2 years

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY S.S. Hospital	21c. (City or town) Sykesville	(County) Carroll	(State) Maryland

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED While at work ☐	Not while at work ☐	21f. HOW DID INJURY OCCUR?
1/	8	55	M.			Patient fell from chair

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James I. Manek M. D.

CHIEF MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 1/27/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-30-55	Buchanan	Buchanan, Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 28, 1955	C. Harry [illegible]	[illegible] N. Haight	Sykesville, Md.

VS. A15A - 5 - 53

FEB 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

004-2

CERTIFICATE OF DEATH

Reg. Dist. No. 00403

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 1 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) R.D. 1

3. NAME OF DECEASED: (Type or Print) (First) DEBORAH (Middle) DIANE (Last) STREVIG

4. DATE OF DEATH: (Month) Jan (Day) 6 (Year) 19 54

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Dec. 27-1953

9. AGE last birthday: 1 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Gettysburg Hosp/Pa.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Elton Strevig

14. MOTHER'S MAIDEN NAME: Mildred Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs Elton Strevig R-2 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Acute Bronchio. Pneumonia — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Viral Respiratory infection — DUE TO — 6 days
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan-6, 19 54, to Jan-6, 19 54, that I last saw the deceased alive on Jan-6, 19 54, and that death occurred at 12 P m., from the causes and on the date stated above.

SIGNATURE James J. Monk — (DEGREE OR TITLE) M.D. — ADDRESS Westminster Md — DATE SIGNED 1-12-6-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Jan 8. 1954 — NAME OF CEMETERY OR CREMATORY Pleasant Cemetery — LOCATION (City, town, or county) Westminster, (State) Md.

DATE REC'D BY LOCAL REG. 1-8-54 — REGISTRAR'S SIGNATURE Hazel Miller

24. FUNERAL DIRECTOR H. Bankard & Son — ADDRESS Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00404

00356 9 **CERTIFICATE OF DEATH** Reg. Dist. No. 36

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 27
HOSPITAL OR INSTITUTION OR STREET ADDRESS 13 George St. west

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster 27
STREET ADDRESS (If rural, give location) 13 west Georgi St.

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) ERNEST (Last) SULLIVAN

4. DATE OF DEATH: (Month) Jan. (Day) 24 (Year) 1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Married	April 21-1872	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer	Times Printing Co.	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
George W. Sullivan	Lucinda Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	212-01-8688	Caroline Rose Sullivan 13 W. George St. Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	Last one 4 days
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Cardio-vascular disease	5 years
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐
0	none	

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
no				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
—	—	—	M.	—	—

22. I hereby certify that I attended the deceased from Jan. 10, 1946, to 1-24, 1955, that I last saw the deceased alive on 1-24, 1955, and that death occurred at 3 P. m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
R. Billingslea	M.D.	Westminster, Md.	1-25-55

23) BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1-27-1955	Krider Cemetery	Westminster,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 26-1955	Hamit Nolle	H. Bankard & Son	Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00405

0043 CERTIFICATE OF DEATH Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY CARROLL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville
LENGTH OF STAY (in this place) 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Market,
STREET ADDRESS (If rural give location) None

3. NAME OF DECEASED: (Type or Print) (First) ELMER (Middle) ELLSWORTH (Last) SUMMERS

4. DATE OF DEATH: (Month) 1 (Day) 12 (Year) 1955

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 6/18/81

9. AGE last birthday: 73 yrs | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hezikiah Summers

14. MOTHER'S MAIDEN NAME: Anna DeLauter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-10-5741

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0
IMMEDIATE CAUSE (A) Myocardial infarction — 1 week
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized arteriosclerotic heart disease — years
DUE TO
(C)

II SIGNIFICANT CONDITIONS CONTRIBUTING DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome, cerebral arteriosclerosis, with psychotic reaction — years

19A. OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/21, 1954 to 1/12, 1955 that I last saw the deceased alive on 1/12, 1955, and that death occurred at 10:50 P.M., from the causes and on the date stated above.
SIGNATURE Edward Fusbaw M D ADDRESS Sykesville, Maryland DATE SIGNED 1/13/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Jan.15,1955
NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery
LOCATION (City, town, or county) (State): Middletown, Maryland

DATE REC'D BY LOCAL REGISTRAR: 14 Jan 1955
REGISTRAR'S SIGNATURE: C. Henry Zile
24. FUNERAL DIRECTOR ADDRESS: M. R. Etchison & Son, Frederick, Maryland

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

00404

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00406

CERTIFICATE OF DEATH

Reg. Dist. No. 2-a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll Co — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster — LENGTH OF STAY (in this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Finksburg RD #1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) Finksburg RD #1

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	DORA	DEAN	TASKER		Jan.	26	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	widowed	Aug 23, 1880	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home-keeper		Alleghany Co. Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard D. Dean	Mary A. McLaughlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
		J. Dean Tasker, Finksburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
443X Immediate cause	(a) PULMONARY EDEMA	6 HRS.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) HYPERTENSIVE - ARTERIOSCLEROTIC C.V. DISEASE	15 YRS.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from JUNE, 1954, to JANUARY, 1955, that I last saw the deceased alive on Jan. 25, 1955, and that death occurred at 8:00 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin E. Strobel	M.D.	Reisterstown, Md.	1/26/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 29 '55	I.O.O.F. Cemetery	Elk Garden W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 27 1955	Hannah Miller	W.H. Wright Funeral Home	

0047 5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00407

CERTIFICATE OF DEATH

Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Manchester
LENGTH OF STAY (in this place) 5 wks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Overview Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester Md X
STREET ADDRESS (If rural, give location) 124-130 N Main St 1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Charles	Edward	Trump	January	26	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widower	May 11 1869	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Agriculture	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Edward Trump	Martha E. Garber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	Unk.	Mrs Albert Wantkins Manchester Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocarditis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Cardio-Vascular Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—	—	—

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
—			m.		—

22. I hereby certify that I attended the deceased from July 1, 1954, to January 26, 1955, that I last saw the deceased alive on Jan 25, 1955, and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Joseph E. Bunds M.D.	Hampstead Md	Jan 26, 1955

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	Jan. 29-55	Manchester	Manchester, Carroll Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 27-55	Mrs. W. P. Lamm	R B Wilt	Manchester Md

RECEIVED
JAN 3[illegible] 19[illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00405 Items 1,9 Filed 2177 3-2-55

CERTIFICATE OF DEATH

00408 Reg. Dist. No. ...

1. PLACE OF DEATH:
COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Sykesville
MARYLAND LENGTH OF STAY (in this place) since 9/17/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS (If not in hospital or institution, give street address or location) Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ---
CITY. If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 3Vol-4
STREET ADDRESS (If rural give location) 414 S. Newkirk

3. NAME OF DECEASED: (Type or Print) (First) Thomas (Middle) - (Last) TSAKALOS

4. DATE OF DEATH: (Month) January (Day) 31 (Year) 1955

5. SEX: male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married | 8. DATE OF BIRTH: 1894 55 unknown March 15 | 9. AGE last birthday 60 yrs. | IF UNDER 1 YEAR Months - Days - | IF UNDER 24 HRS. Hours - Min. -

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown | 10B. KIND OF BUSINESS OR INDUSTRY: --- | 11. BIRTHPLACE (State or foreign country): Greece | 12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: unknown | 14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no | (If Yes, give war or dates of service) --- | 16. SOCIAL SECURITY NO. unknown | 17. INFORMANT & ADDRESS. Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Tumor of right occipital lobe (type pending microscopic examination) — more than 5 yrs.

(C) ---

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with circulatory disturbance, cerebral arteriosclerosis) — About 4 yrs.

19A. DATE OF OPERATION: --- | 19B. MAJOR FINDINGS OF OPERATION --- | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) --- | 21C. WHERE DID INJURY OCCUR? (City or town) --- (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. --- | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Dec. 13, 1954 to Jan. 30, 1955 that I last saw the deceased alive on Jan. 30, 1955, and that death occurred at 1:35 A.M., from the causes and on the date stated above.

SIGNATURE Florian Nadolski | M.D. | ADDRESS Sykesville, Md. | DATE SIGNED 1/31/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 2-2-55 | NAME OF CEMETERY OR CREMATORY Mech Orthodox Cem Windsor Mill Road | LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR 2-2-55 | REGISTRAR'S SIGNATURE A.W. Lobdell | 24. FUNERAL DIRECTOR Mech Funeral Inc | ADDRESS 440 E North Ave

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00409

00407

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carrol MARYLAND
X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 7 mths
15 HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 6
STREET ADDRESS (If rural give location) 4508 Schley Ave

3. NAME OF DECEASED: (Type or Print) (First) ANNA (Middle) BARBARA (Last) VALIS

4. DATE OF DEATH: (Month) January (Day) 10 (Year) 1955

5. SEX: Fem. | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed | 8. DATE OF BIRTH: 10-12-89 | 9. AGE last birthday: 65 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife | 10B. KIND OF BUSINESS OR INDUSTRY: — | 11. BIRTHPLACE (State or foreign country): Bohemia (Czechoslovakia) | 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: J. SLUKA | 14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) — | 16. SOCIAL SECURITY NO. — | 17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Hypertensive Cardiovascular disease	years
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Chronic Brain syndrome, presenile brain disease	7 years
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Chronic Brain syndrome, psychotic reaction	5-7 years

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 18, 1954 to 1-10-, 1955, that I last saw the deceased alive on 1-10-, 1955, and that death occurred at 2:15 PM, from the causes and on the date stated above.

SIGNATURE Gertrud Sommerfeld M.D. | ADDRESS Springfield State Hospital Sykesville Md. | DATE SIGNED 1-10-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | DATE THEREOF: Jan. 14, 1955 | NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem. | LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR: 1-13-55 | REGISTRAR'S SIGNATURE: [illegible] | 24. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. | ADDRESS: 2601-3-5 E. Madison St.

00498

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00410

CERTIFICATE OF DEATH

Reg. Dist. No. 77

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Hampstead (Rural) LENGTH OF STAY (In this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead - (Rural) X
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) NAOMI (Middle) M (Last) WALSH

4. DATE OF DEATH (Month) Jan (Day) 26 (Year) 1955

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH May 14-1901 | 9. AGE last birthday 53 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Md | 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Cecil A Snyder | 14. MOTHER'S MAIDEN NAME Dessie A Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS Paul J Walsh - Hampstead Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X

Immediate cause (a) Pulmonary Edema — Interval Between Onset and Death: 20 hrs.

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Adeno Carcinoma Breast Lt. E — 3 1/2 yrs.

(c) Generalized. Metastases.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/ix, 1954, to 1/26, 1955, that I last saw the deceased alive on 1/26, 1955, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm. A. Carter M.D. Westminster Md. 1/27/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Jan 29/55 | NAME OF CEMETERY OR CREMATORY Ashton | LOCATION (City, town, or county) (State) Carroll Co Md

DATE RECD BY LOCAL REG. 1/28/55 | REGISTRAR'S SIGNATURE Henry Reese | 24. FUNERAL DIRECTOR ADDRESS Edw. C. Gipton Hampstead Md

RECEIVED
FEB 1
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00479

CERTIFICATE OF DEATH

Reg. Dist. No. 0041

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville
LENGTH OF STAY (in this place) 19 Y 6 M 24 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, Maryland
STREET ADDRESS (If rural give location) 224 South Chestnut Street

3. NAME OF DECEASED: (First) John Francis (Middle) (Last) WATERS

4. DATE OF DEATH: (Month) 1 (Day) 11 (Year) 19 55

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 6/10/86

9. AGE last birthday 68 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John H. Waters

14. MOTHER'S MAIDEN NAME: Mary Clara Sherwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Uremia — 48 hours

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

DUE TO (B) Generalized Arteriosclerosis — years

DUE TO (C) Widespread skin papillomata — 8 years

II SIGNIFICANT CONDITIONS CONTRIBUTING DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. CRS, Convulsive disorder, arteriosclerosis of cerebral vessels — years

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1/50, 19 , to 1/11 , 19 55 that I last saw the deceased alive on 1/10/ , 1955 , and that death occurred at 4:25 PM, from the causes and on the date stated above.

SIGNATURE Walter H. Timmerdelle M. D. — ADDRESS Sykesville, Maryland — DATE SIGNED 1/11/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Jan 13, 1955 — NAME OF CEMETERY OR CREMATORY New Cathedral — LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REGISTRAR 1-12-55 — REGISTRAR'S SIGNATURE A. W. Nelson

24. FUNERAL DIRECTOR S. Truman Schaal — ADDRESS

00360
00357

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00412

CERTIFICATE OF DEATH

Reg. Dist. No. 26

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster — LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 67 W. Main Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 67 W. Main St.

3. NAME OF DECEASED (Type or Print): (First) Elizabeth — (Middle) ------ — (Last) Weeks

4. DATE OF DEATH: (Month) Jan. (Day) 14 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Mar. 6, 1873

9. AGE last birthday: 81 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Weeks

14. MOTHER'S MAIDEN NAME: Lydia Ann Frock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO. - - - - - -

17. INFORMANT AND ADDRESS: Mary Belle Weeks Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Paralysis Agitans — Interval between onset and death: 29 mos.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Chr. Cerebro-Arterios. — 10 years
(c) Chr. Hypostatic — 15 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 10th, 1954, to Jan 14th, 1955, that I last saw the deceased alive on Jan 14th, 1955, and that death occurred at 8:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Charles Barr M.D. Westminster Maryland 1/15/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan. 17, 1955 — NAME OF CEMETERY OR CREMATORY: Krider's Cemetery — LOCATION (City, town, or county) (State): nr Westminster, Md.

DATE REC'D BY LOCAL REG. 1-18-55 — REGISTRAR'S SIGNATURE Harriet Fuller

24. FUNERAL DIRECTOR: John R. Byers — ADDRESS: Westminster, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00413

00410. **CERTIFICATE OF DEATH** Reg. Dist. No. 70

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Taneytown
LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown X
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Viola (Last) Weishaar

4. DATE OF DEATH: (Month) January (Day) 18, (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: June 13, 1909

9. AGE last birthday 45 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William F. Weishaar

14. MOTHER'S MAIDEN NAME: Clara M. Starner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-05-0638

17. INFORMANT & ADDRESS: William F. Weishaar, Taneytown, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE 4427 (A) Chronic Myocarditis and Myocardial degeneration. — 2 yrs.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Hypertensive Cardio-Renal Disease — 4 years

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Obesity Acute Upper Respiratory Infection — Life 2 wks.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/20, 1954, to 1/18, 1955, that I last saw the deceased alive on 1/17, 1955, and that death occurred at 3 P. M, from the causes and on the date stated above.

SIGNATURE R. D. McVaugh M. D. ADDRESS Taneytown, Md. DATE SIGNED 1/20/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Jan. 21, 1955 — NAME OF CEMETERY OR CREMATORY Baust Cemetery — LOCATION (City, town, or county) (State) Tyrone, Maryland

DATE REC'D BY LOCAL REGISTRAR Jan 20 1955 — REGISTRAR'S SIGNATURE Ethel M Mehring

24. FUNERAL DIRECTOR ADDRESS C.O.Fuss & Son, Taneytown, Maryland

RECEIVED
JAN 24 1955
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00414

00411

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH: Carroll COUNTY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sykesville
LENGTH OF STAY (in this place): 15
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland STATE Baltimore City COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
STREET ADDRESS (If rural give location): 2930 Keswick Road, Balto 11

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) George (Last) Wolverton
4. DATE OF DEATH: (Month) 1- (Day) 23 - (Year) 19 55
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): X
8. DATE OF BIRTH: 10-11-78
9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dep.Gend.
10B. KIND OF BUSINESS OR INDUSTRY: Truck driver
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Scott Wolverton
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service): 9
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT & ADDRESS: Ella Calp-2930 Keswick Road, Balto, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Thrombosis — 2days
DUE TO
ANTECEDENT CAUSE (B) Arteriosclerotic cardiovascular disease — years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome assoc.with cerebral — years

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION arteriosclerotic disease
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-4-55, 19..., to 1-23-..., 19 55 that I last saw the deceased alive on 1-21-..., 19 55, and that death occurred at 2:30 A M, from the causes and on the date stated above.
SIGNATURE Edmund Guttmann M. D. ADDRESS Springfield State Hospital DATE SIGNED 1-23-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
DATE THEREOF: 1-26-1955
NAME OF CEMETERY OR CREMATORY: Greenmount
LOCATION (City, town, or county) (State): Baltimore - Maryland
DATE REC'D BY LOCAL REGISTRAR: 1-25-55
REGISTRAR'S SIGNATURE: [illegible]
24. FUNERAL DIRECTOR AND ADDRESS: Earl B. Wolverton Funeral Home Inc 402 E. 25th St. Baltimore 18, Md

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING